Accountable Care Collaboratives:

The Drive to High-Value Healthcare

January 2011

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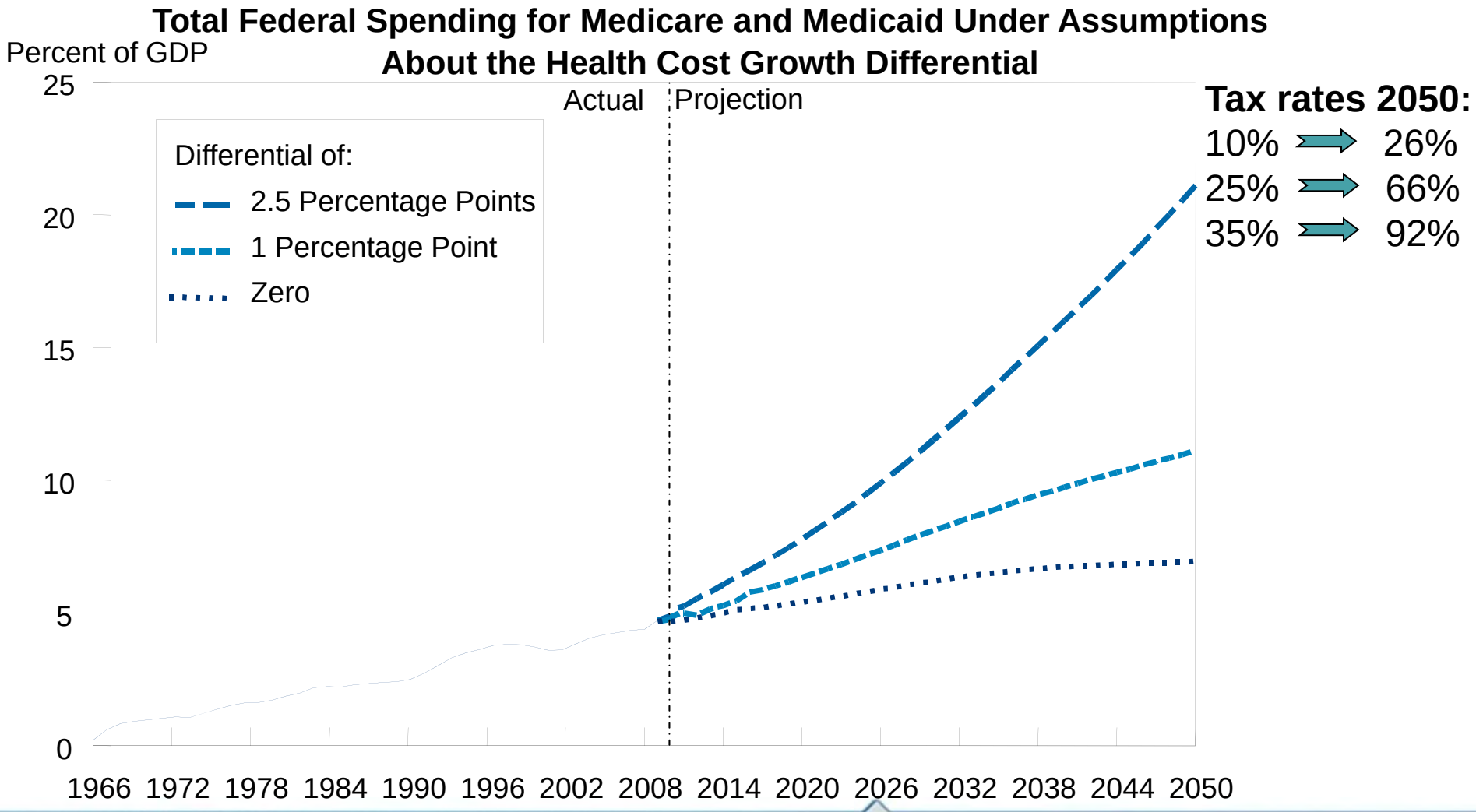
Today's presentation

- Healthcare reform's "bending-the-cost-curve" strategy
  - Alignment with DOD's priority
- Accountable Care Organization: what, when, how?
- Premier's Accountable Care Collaborative
  - Goals and requirements
  - Component parts
  - Participants
- Regulatory timeline and issues

The hidden agenda



The Overarching Strategic Umbrella of Healthcare Reform

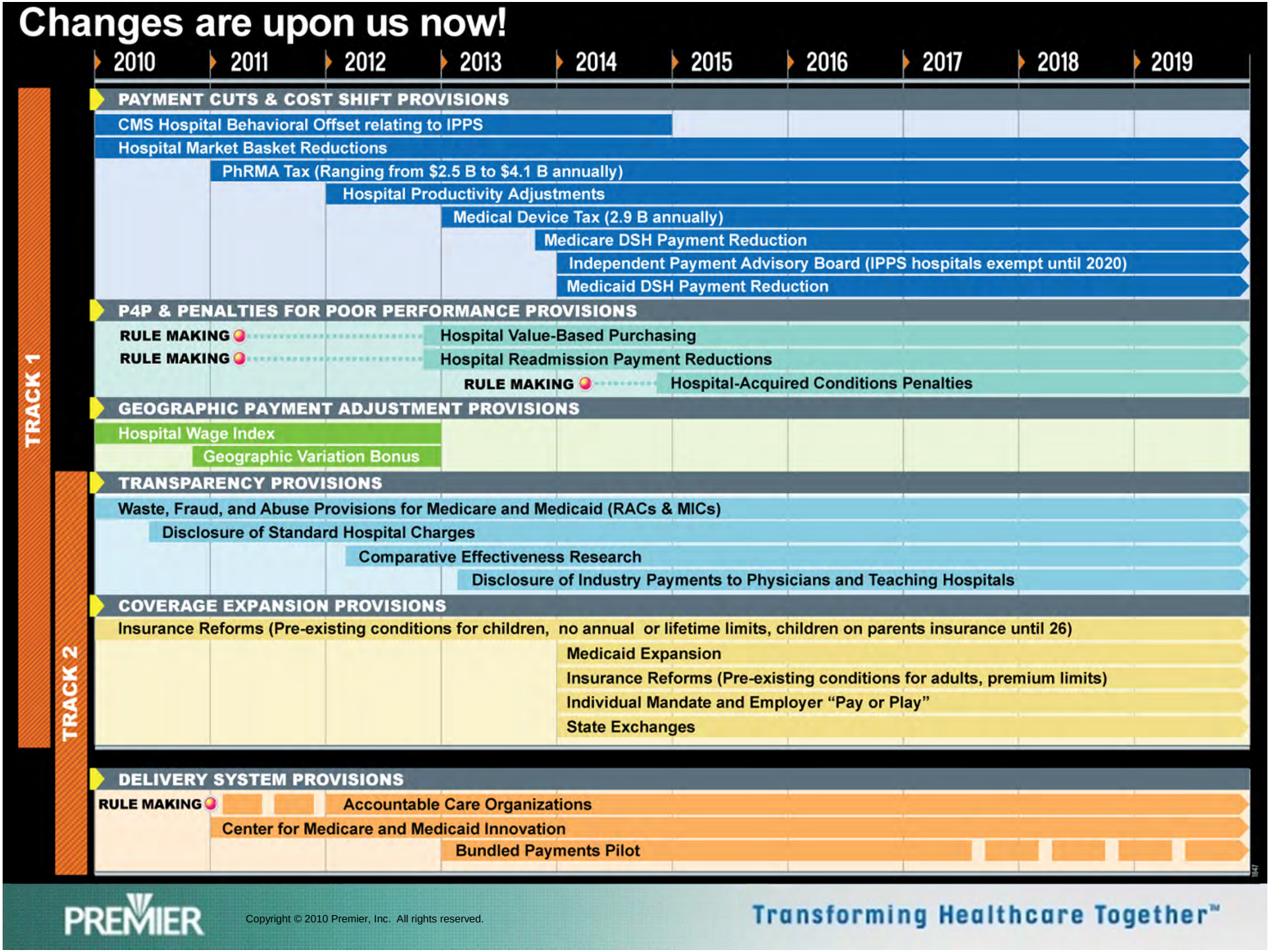
Cuts to Existing FFS System

- Market basket reductions
- DHS cuts
- Nonpayment for anything preventable or unnecessary

Disrupt Existing System

- Bundled Payments
- Innovation Center
- Demonstrations
- ACOs

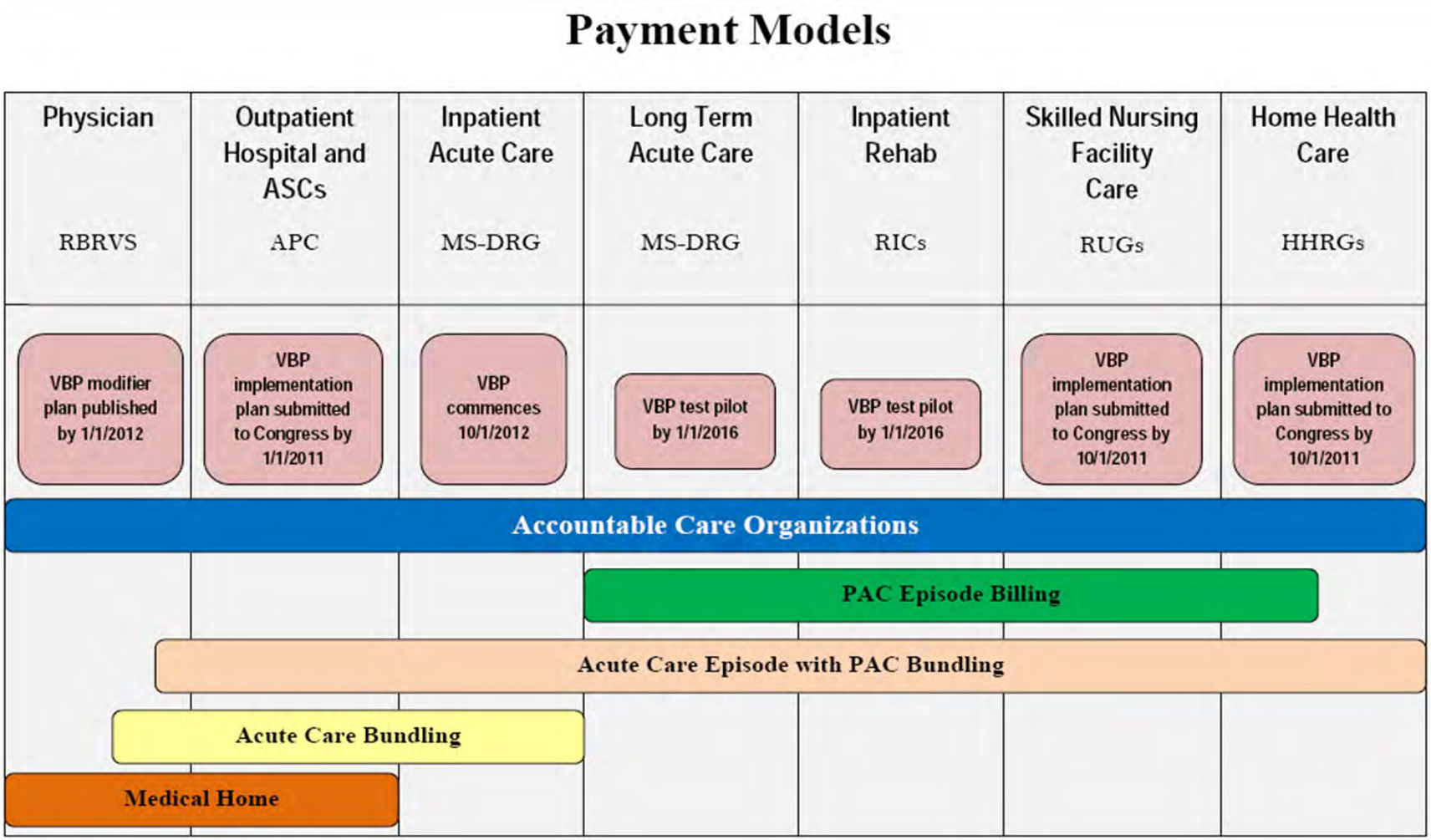
Changes are upon us now!



PREMIER

Transforming Healthcare Together™

Payment reform across the payment silos



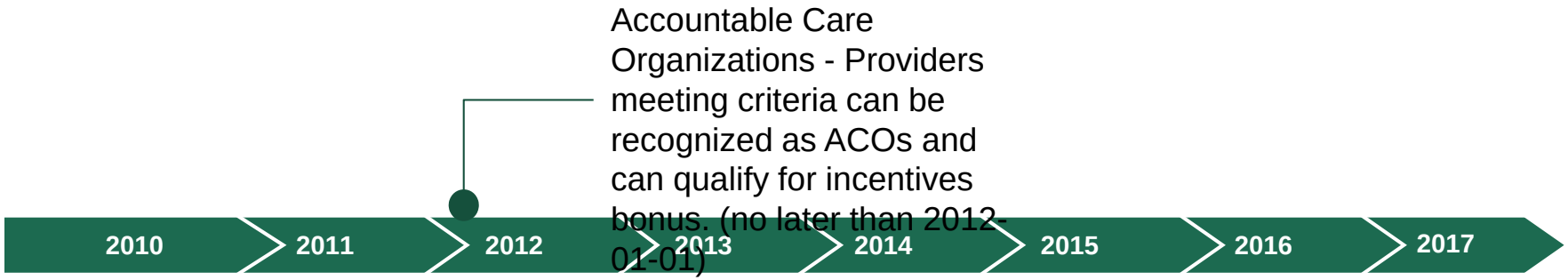
The DOD & the Nations Ultimate Goal

- **Readiness**
  - Pre- and Post-deployment
  - Family Health
  - Behavioral Health
  - Professional Competency/Currency
- **Population Health**
  - Healthy service members, families, and retirees
  - Quality health care outcomes
- **A Positive Patient Experience**
  - Patient and Family centered Care, Access, Satisfaction
- **Cost**
  - Responsibly Managed

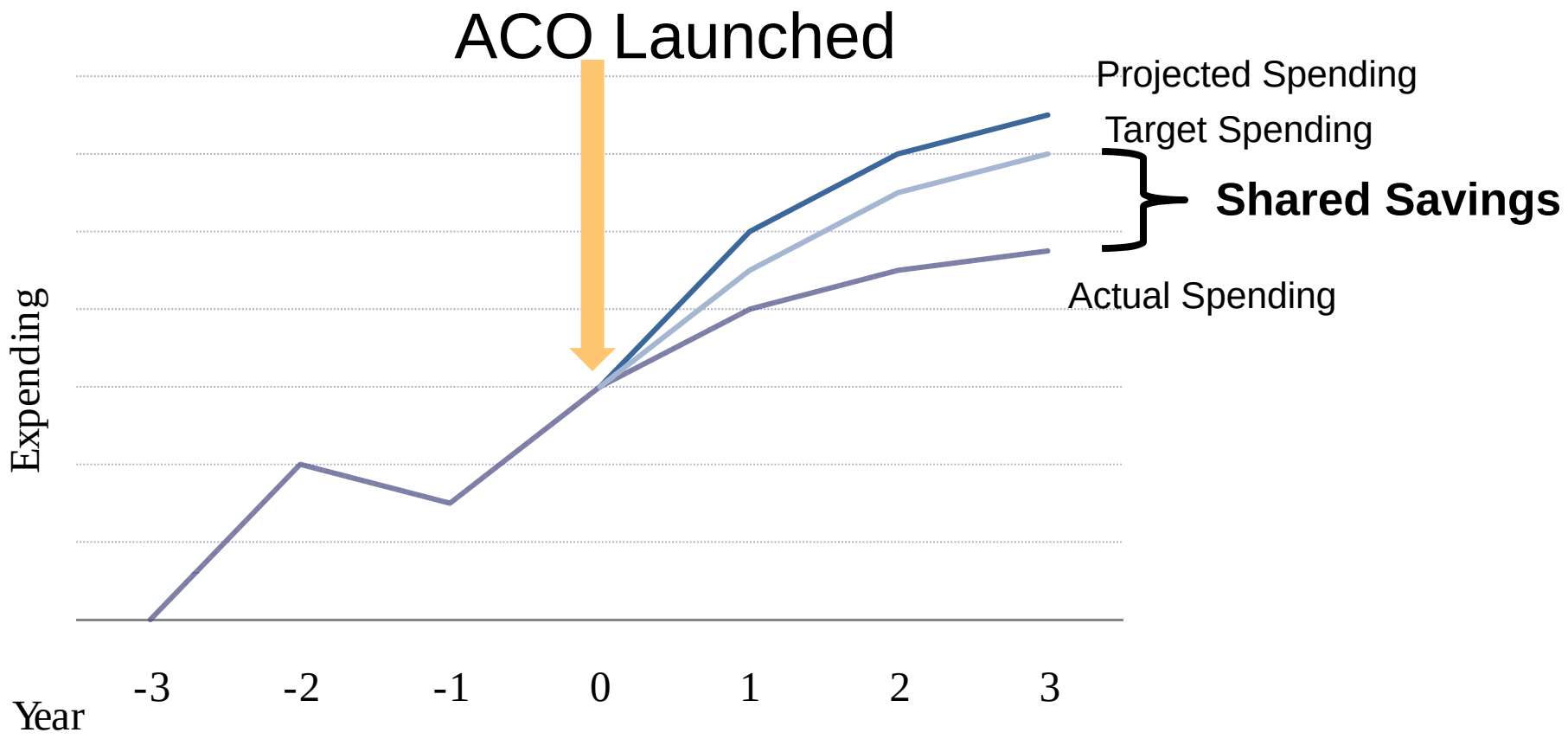
Accountable Care Organizations:

Healthcare reform provision

- **Broad range of providers able to initiate ACOs**
- Accountability for total cost, quality and care of beneficiaries
- 3-year participation commitment
- Legal structure to receive and distribute savings
- Primary care physicians to cover a minimum of 5,000 Medicare beneficiaries
- Defined processes for evidence-based medicine and patient engagement, quality and cost measures reporting and telehealth, remote patient monitoring, etc.
- Patient-centeredness
- No participation in other government-based shared savings demonstration projects
- **Allows CMS to join existing ACOs with payment models beyond fee-for-service**
- **CMS may give preference to ACOs already contracting with private market**
- Saves $4.9 B over 10 years
- Allows pediatric providers to form ACOs through state Medicaid programs (2012)



ACO Shared Savings



Source: Lewis, Julie. *"What Could be Next for Health Reform? The Debate In Washington" Presentation*. The Dartmouth Institute for Health Policy & Clinical Practice. 2009-07-02.

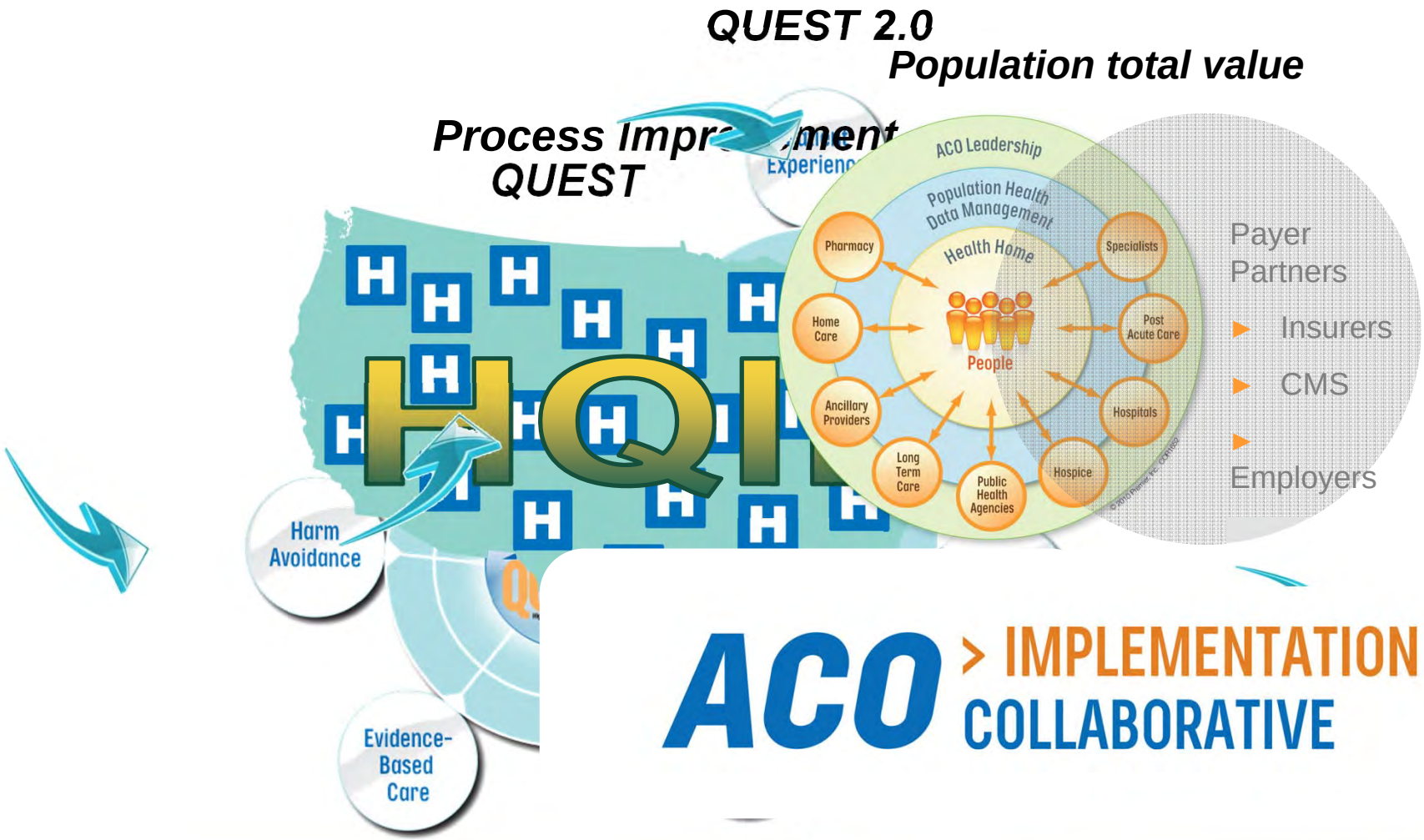
Physician Group Practice (PGP) - CMS Demo

- Test bed for demonstrating ACO models
- Creates incentives for physician groups to coordinate the overall care delivered to Medicare beneficiaries
- Shared savings based on improved quality and cost efficiency
- Enables collaboration among providers to benefit Medicare beneficiaries
- Demo goals (5 year demonstration):
  - Coordination of Part A and Part B services
  - Promote cost efficiency and effectiveness through investment in care management programs, process redesign, and tools for physicians and their clinical care teams
  - Reward physicians for improving health outcomes (32 quality measures) by sharing in financial savings

PGP Outcomes… So far (as of 8/2009)

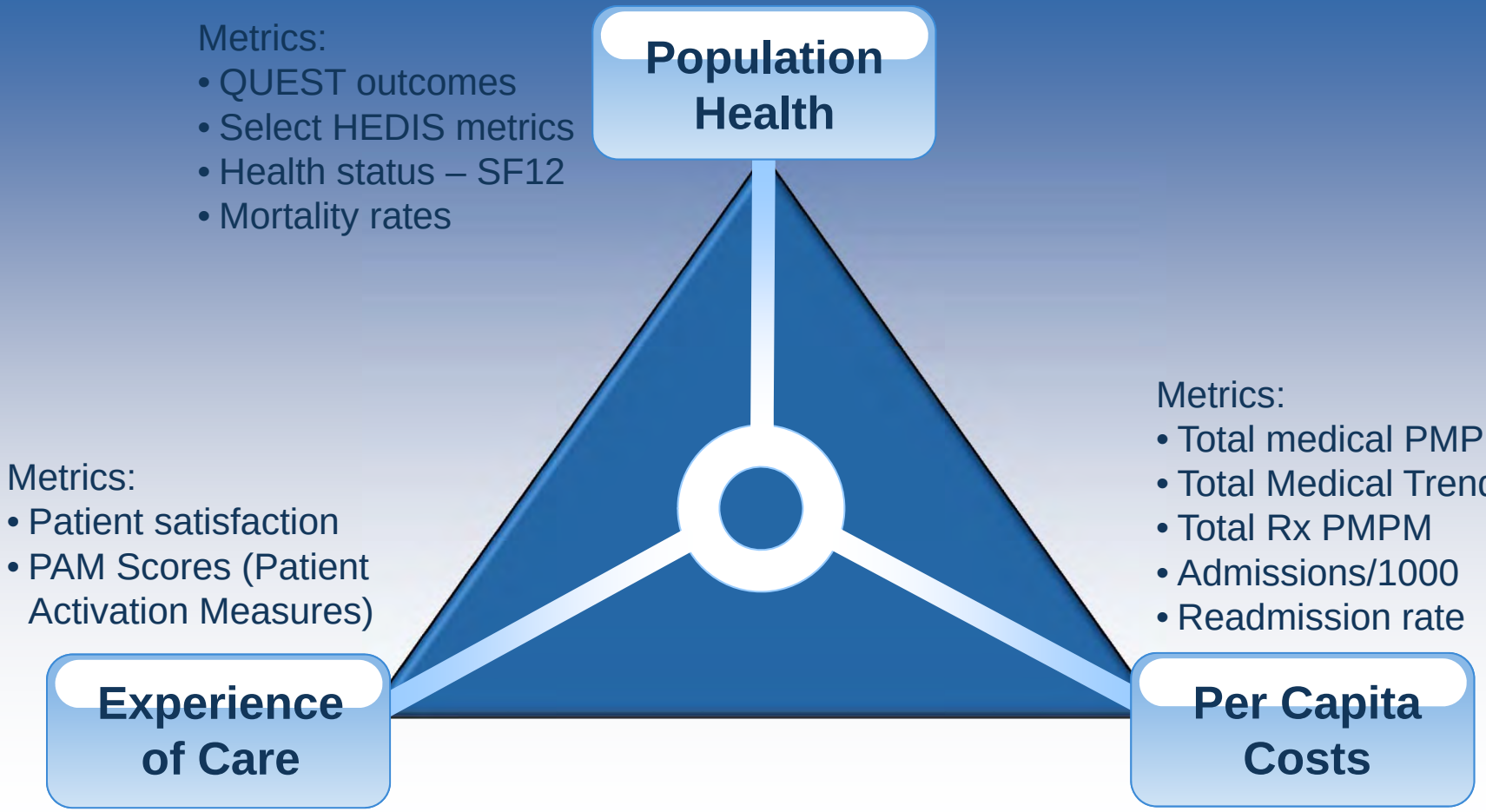
- Three-year average quality-improvement results:
  - 10 percentage points on the diabetes,
  - 11 percentage points on the congestive heart failure measures,
  - 6 percentage points on the coronary artery disease measures,
  - 10 percentage points on the cancer screening measures, and
  - 1 percentage point on the hypertension measures.
- Five participants earned $25.3 million in performance payments for improving quality and achieving savings of $32.3 million:
  1. Dartmouth-Hitchcock Clinic
  2. Geisinger Clinic
  3. Marshfield Clinic
  4. St. John's Health System, and
  5. The University of Michigan Faculty Group Practice

Journey to high-value healthcare



Definition of Success:

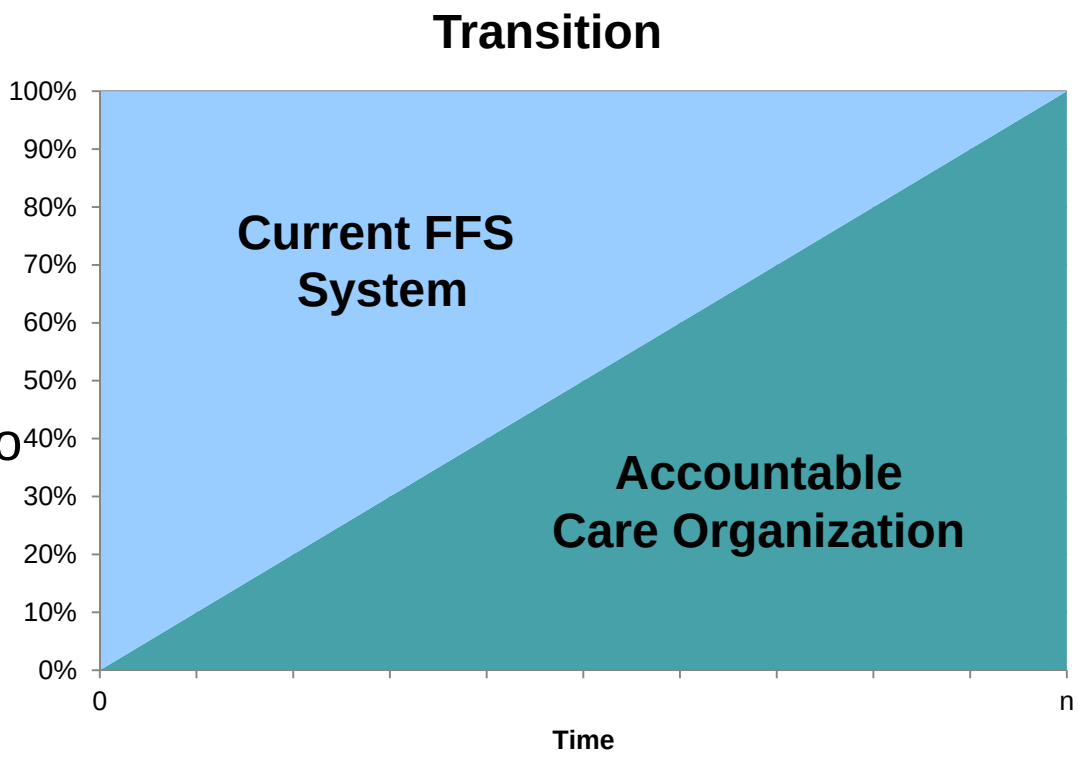
Improving triple aim™ population outcomes



The term triple aim is a trademark of the Institute for Healthcare Improvement

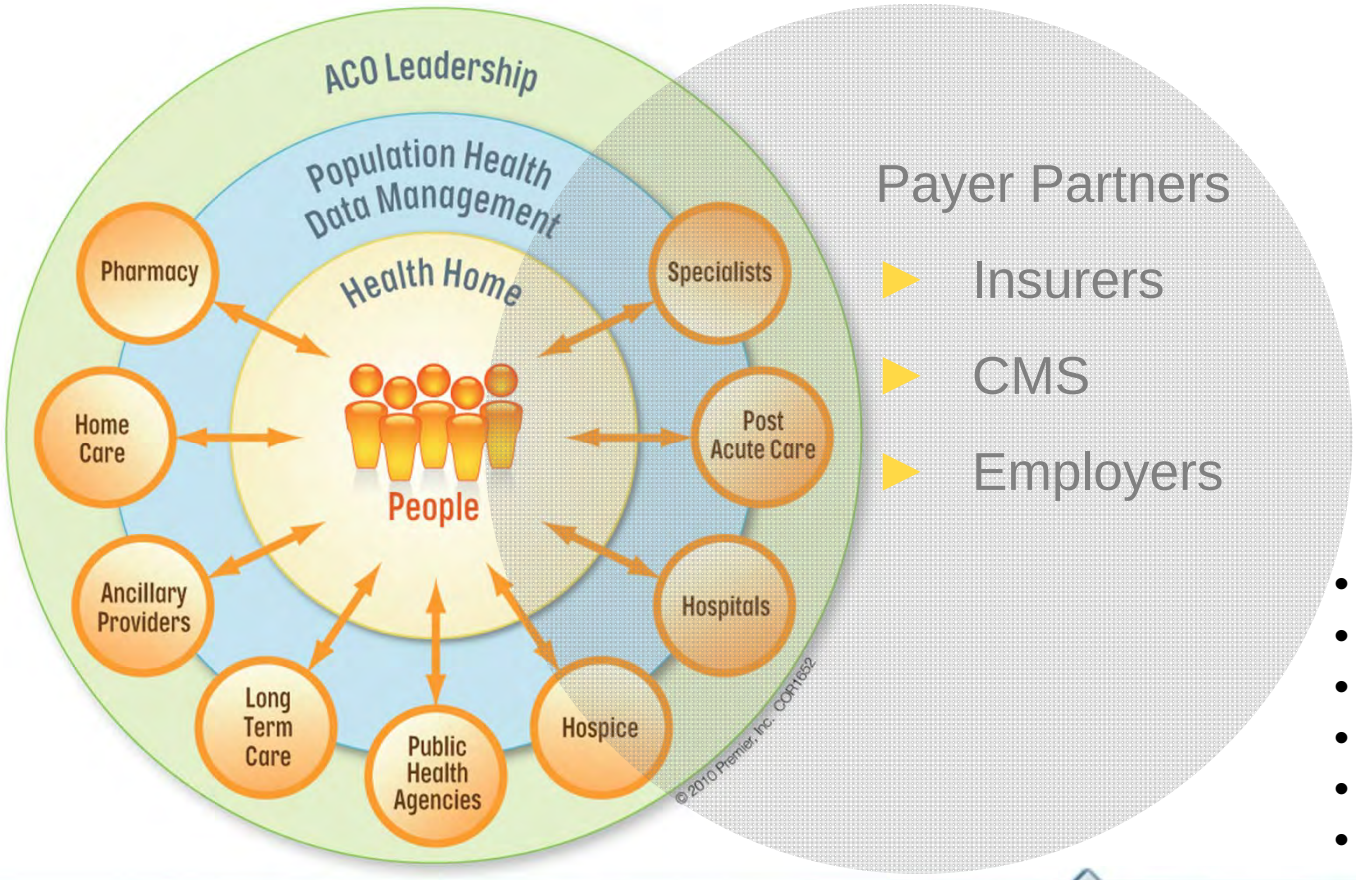
Movement Towards ACO Raises Key Questions

- What is the COST impact of delivering accountable care?
- What is the REVENUE impact of delivering accountable care?
- What is the COST impact of building an ACO?
- How do you manage the hospital and physician relationship through transition to an ACO?
- How do you manage two parallel entities through the transition?
- How do you manage the pace of that transition?



ACO model: Six core components

A group of providers willing and capable of accepting accountability for the total cost and quality of care for a defined population.



Core Components

- People Centered
- Health Home
- High-Value Network
- Population Health Data
- ACO Leadership
- Payer Partnerships

Components and Capabilities

Health Home
A. Deliver People Centered Primary Care
B. Optimize Chronic, Acute and Preventative Care
C. Manage Population Segments to Optimize Health Status
D. Coordinate Care Across Continuum
E. Health Home Value Care Systems
F. Drive Continuous Improvement in Practice Population Outcomes
G. Develop New Care Models to Improve Specific Clinical Conditions Across the Spectrum of Care

People Centered Foundation
A. Involve People in Decisions that Affect their Health Care
B. Provide People with Easy Access to Health Care
C. Activate Individuals to Take Responsibility for their Own Health
D. Regularly Assess and Address Individuals' and Population's Needs
E. Measure and Improve the Experience of People within the ACO Population

Payor Partnership
A. Negotiate and Manage ACO Contract with Payer Partners
B. Design aligning incentive systems for ACO members that may be administered by Payer Partner
C. Collaborate with Payer Partners to Manage Population Experience

High Value Network
A. Deliver High Value Specialist Care
B. Deliver High Value Outpatient Facility Services
C. Deliver High Value Inpatient Services
D. Deliver High Value Post-Acute Care
E. Integrate and Coordinate Care Across the Spectrum
F. Drive Continuous Improvement in ACO Population Outcomes
G. Develop New Care Models to Improve Specific Clinical Conditions Across the Spectrum of Care

Population Health Data Management
A. Capture and Analyze Data from Multiple Sources
B. Applications and Systems that Enable Population Health Management
C. Information Exchanges and Communication Pathways for ACO Patients & Participants

ACO Leadership
A. Use Reimbursement to Align ACO Participants with ACO Objectives
B. Provide ACO Wide Results Reports to all Participants
C. Communicate Consistently and Routinely to all Participants
D. Provide Strategic Management of ACO Entity
E. Manage ACO as a Combined Physician Hospital Entity
F. Provide Centralized Medical Management Functions
G. Report on and Facilitate Management of Total Medical Cost
H. Manage Intra-ACO Transfer Prices / Costs
I. Manage Financial Performance of ACO
J. Oversee Triple Aim Outcomes for Entire Population
K. Effectively Manage the Operational Transitions Required to Create an ACO
L. Develop an Organizational Culture Consistent with an ACO System
M. Train Physicians and Other Leaders in Leadership Development in Order to Foster Effective Leadership in a New ACO System
N. Enable ACO Contracting
O. Evaluate, Analyze, Establish Appropriate Legal Structure
P. Educate and Appropriately Manage Interactions Across and Between ACO Parties
Q. Impact and Monitor ACO Regulatory and Legislative Environment

Building health home capabilities

REQUIREMENTS

- Deliver primary care
- Manage population outcomes
- Optimize chronic disease care
- Coordinate care across the spectrum of care

COLLABORATIVE DELIVERABLES

- Physician alignment strategies, including alternative compensation and contracting models.
- Health home models & toolkits
- Health home report set
- Chronic disease care optimization systems
- Predictive modeling tools & techniques
- Case management operations procedures and training program
- Quality improvement common metrics

Building high-value care networks

REQUIREMENTS

- Establish high value networks for:
  - Specialists/ancillaries
  - Inpatient care
  - Outpatient facility care
- Drive continuous improvement
- Manage non-par contracts

COLLABORATIVE DELIVERABLES

- Physician profiling toolkit
- Inpatient care improvement programs (QUEST)
- Imaging optimization program
- Care models for acute and post acute care
- Episode of care best practice models
- Global payment models
- Transitions of care program

Interested health systems are taking one of two positions

We have a business case to rapidly become accountable for the total cost and quality of care for a defined population.

We want to explore the implications of "accountability" and begin building some of the capabilities

Different degrees of commitment for members

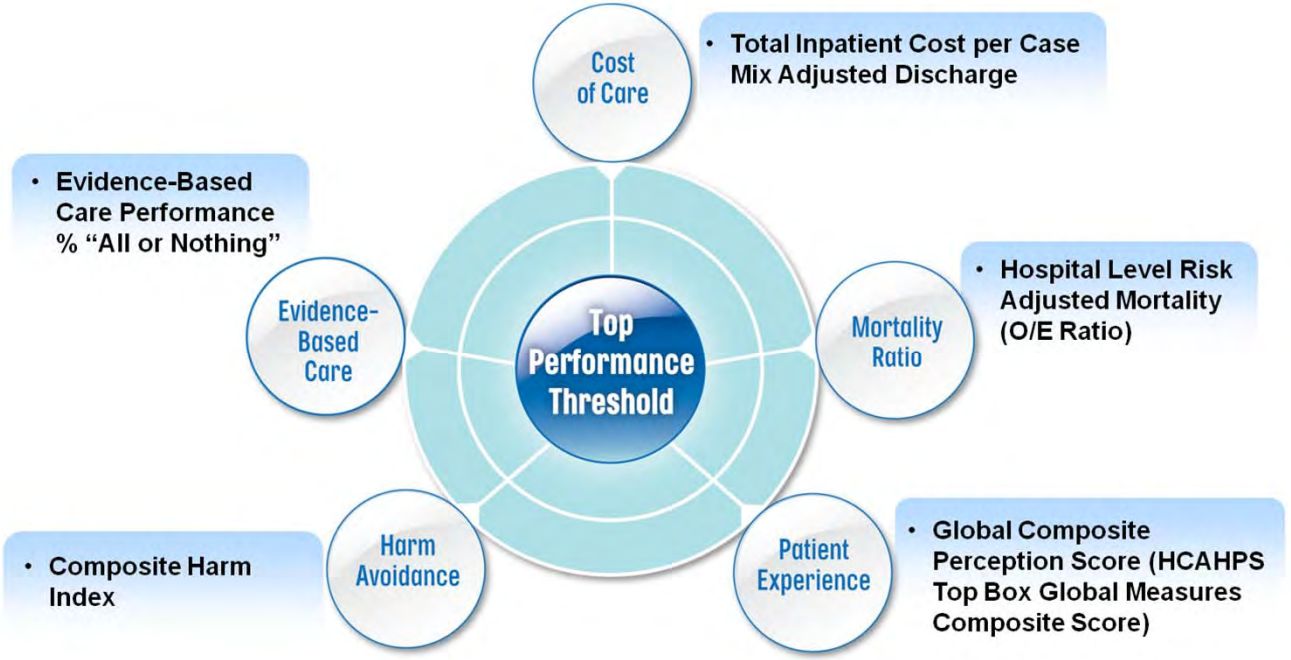
ACO Implementation Collaborative

- Ready to begin implementing
- Executive sponsorship & participation
- Payer partner participation
- Physician network & sufficient population base
- Transparency and acceptance of common cost/quality metrics (QUEST)
- Population health data infrastructure
- Participation in work groups and meetings
- ACO contracting vehicle

ACO Readiness Collaborative

- Capabilities assessment to pinpoint focus areas
- Participation in monthly webinars focused on execution strategies (including members of Implementation Collaborative)
- Online portal of ACO content including toolkits, methodologies, and related content
- Preparation to collect population-based measures
- Milestones to keep on track to join the ACO Implementation Collaborative

Inpatient performance improvement a must!



	Year 1	18 Months	Year 2
Lives saved	8,043	14,649	22,164
Dollars saved	$577M	$1.036B	$2.13B
Patients receiving EBC	24,818	41,130	43,741

Proposed Phase I measures

Premier ACO Collaborative - Phase 1 measure set

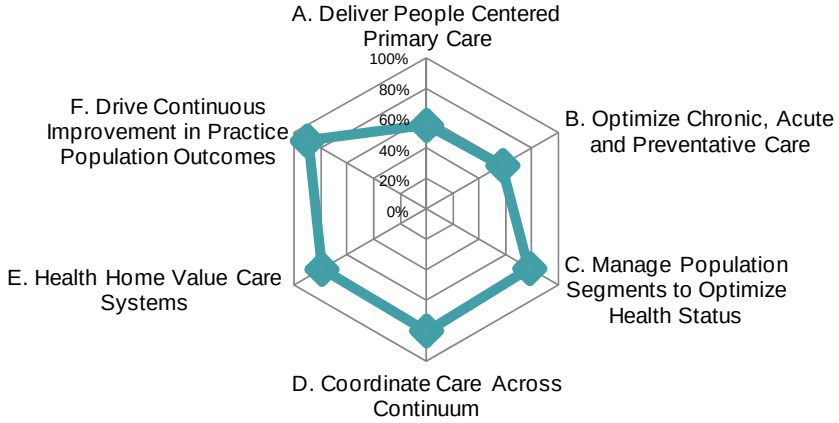
AIM	Sub Aim	Final Metric #	Metric Description	Definition Source	Data Source
Triple Aim One: Health of Population	Primary and Secondary Prevention - Preventing Disease and Disease Progression	f1	HEDIS: Colorectal Screening, adults 50 - 75	NCQA	Claims and Ambulatory (optional)
		f2	HEDIS: Breast Cancer Screening, females 40 - 69	NCQA	Claims
		f3	HEDIS: Flu Shot for Older Adults, adults 65+	NCQA	CAHPS Survey (Medicare)
		f4	HEDIS: Pneumonia Vaccination Status for Older Adults, adults 65+	NCQA	CAHPS Survey (Medicare)
		f5	HEDIS: Comprehensive Diabetes Care – HbA1c control (<8%), 18-75	NCQA	Claims and Ambulatory (optional)
	Tertiary Prevention - Preventing Disease Related Complica-tions	f6	QUEST: Prevention of Harm (composite)	Premier	Discharge Abstract
		f7	QUEST: Risk Adjusted mortality / 1000	Premier	Discharge Abstract
		f8	QUEST: Composite Score of Evidence Based Care for Hospitalized Cases	Premier	Premier
Triple Aim Two: Experience of Care	Satisfaction	f9	HEDIS: Global Rating of All Health Care	NCQA	CAHPS Survey
		f10	HEDIS: Global Rating of Personal Doctor	NCQA	CAHPS Survey
		f11	HEDIS: Global Rating of Specialist Seen Most Often	NCQA	CAHPS Survey
		f12	HEDIS: Composites Score of Getting Needed Care	NCQA	CAHPS Survey
		f13	HEDIS: Composite Score of Shared Decision Making	NCQA	CAHPS Survey
Triple Aim Three: Cost per Capita and Services Delivered	Cost PMPM	f14	Total Cost PMPM (e.g. medical and Rx)	TBD	Medical Claims Rx Claims (when appropriate) Eligibility
		f15	Total Cost PMPM Trend	TBD	Source of data is via f18 source
	Utilization	f16	Admits per 1000 members / year (possibly w/case-mix)	TBD	Claims and Discharge Abstract
		f17	30 day readmit (all cause) rate	TBD	Claims
		f18	ED Visits/1000	TBD	Claims
		f19	Hospital Admissions for Ambulatory Sensitive Conditions (likely w/ case-mix)	AHRQ	Claims and Discharge Abstract

Capabilities Assessment

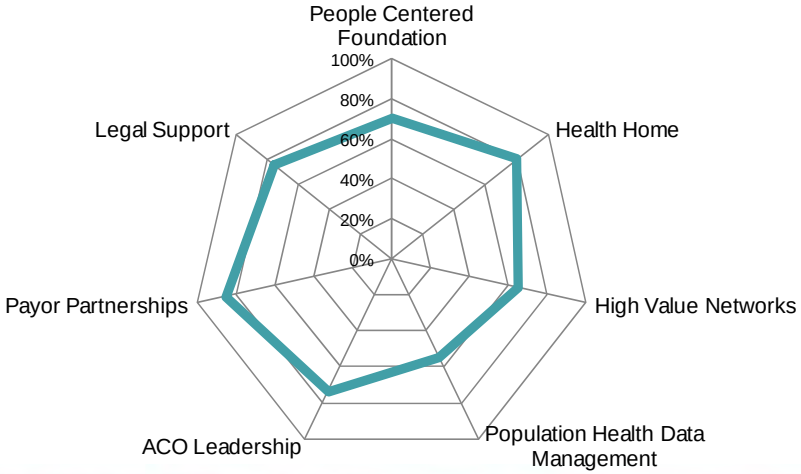
Assessment of each ACO Component:
Per Capability
Per Operating Activity

Outline of "Needs" per each ACO Component:
Which prioritized Capabilities and Operating Activities require the most focus for your organization?

Value Driven Health Home

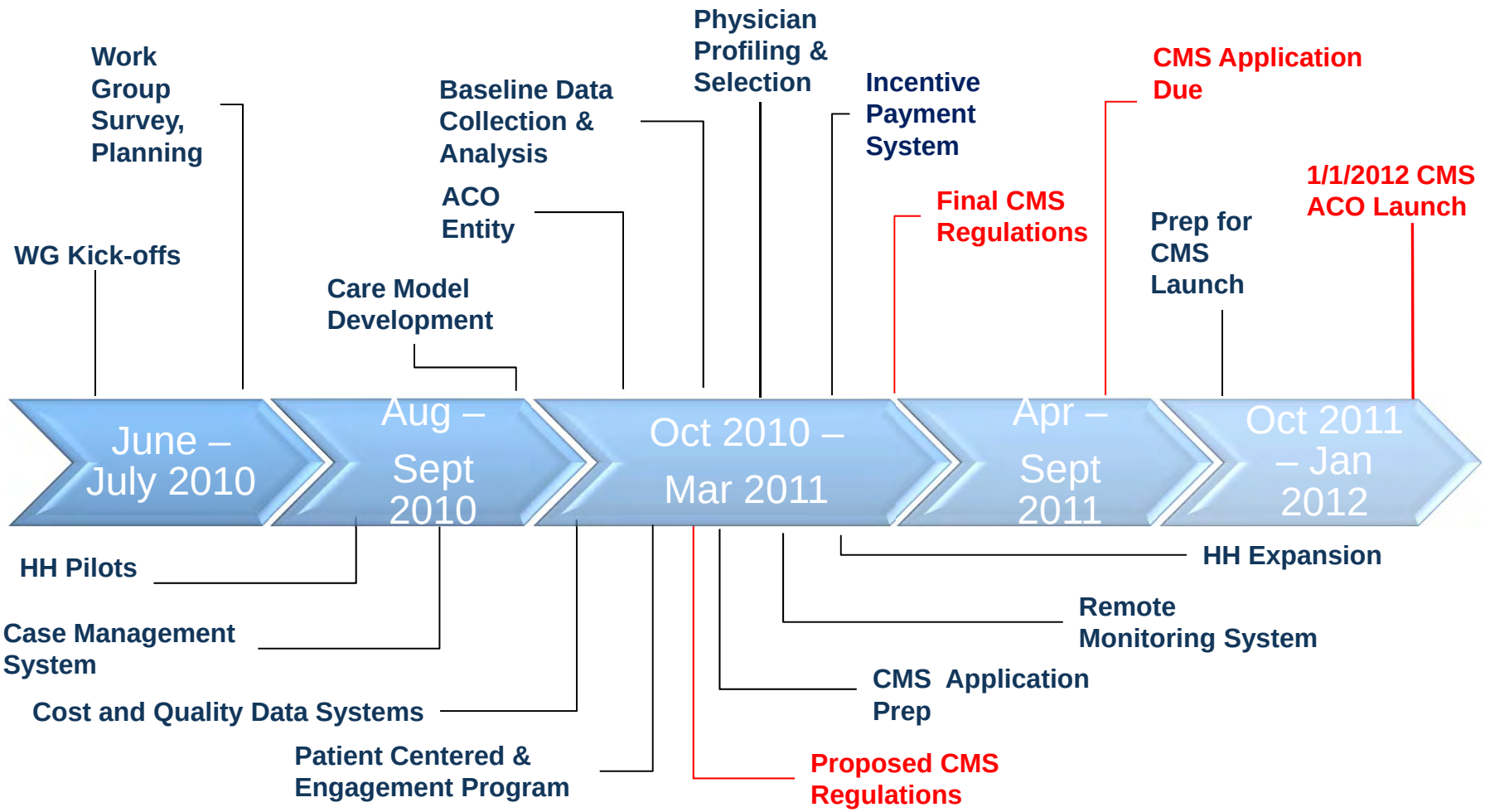


Overall ACO Implementation Status



Assessment of Overall ACO Status:
Per Each Component
Consideration of Market Forces
Alignment to Strategy

Action is Necessary to Meet Possible CMS Timetable



Key design issues

- Beneficiary opt-out, transparency and inducements
- Timely access to A, B & D claims data and beneficiary list
- Encourage other payers (Medicaid, private)
- Legal (anti-trust, anti-kickback…) “safe harbors”
- Hospitals can organize
- Permit partial or full capitation